Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TX 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 15

MFDR Tracking Number
M4-11-3503-01

MFDR Date Received
JUNE 13, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Our facility has sent a status request and a request for reconsideration, which have not been replied to. Therefore does not give us an avenue to properly seek reimbursement for services we provided. This is also in violation of Rule 133.240. The request for reconsideration and this MDR are being filed in order to comply with the requirements of RULE §133.250(b) AND RULE §133.305."

Amount in Dispute: $106.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent has to received the medical bill in dispute in this matter. Requestor attached a fax confirmation sheet which shows that the medical bill for the date of service 9/2/10 was faxed to 800-408-4131. This is not a fax number for the Carrier. Further, attached are other medical bills submitted by Requestor to Respondent for the same Claimant and same date of injury in which Requestor used the correct fax number; thus, this is proof that Requestor knew the correct fax number to send medical bills and correspondence to Respondent and did not use it. In conclusion, Respondent has not been presented these bills for processing. This dispute is not proper at the appropriate administrative channels for bill processing have not yet been exhausted."

Response Submitted by: Downs-Stanford, Inc., 2001 Bryan St., Ste. 4000, Dallas, TX 75201

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 2, 2010	CPT Code 99213	$106.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. The services in dispute were reduced/denied by the respondent with the following reason codes:
   No EOBs presented by either party

Issues

1. Did the requestor fax the medical bill to the correct fax number for respondent?
2. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307(d)(2)(C) if the carrier did not receive the provider's disputed billing or the employee's reimbursement request relevant to the dispute prior to the request, the carrier shall include that information in a written statement in the response the carrier submits to the Division. The respondent has stated in their position summary, "…Respondent has not been presented these bills for processing. This dispute is not proper as the appropriate administrative channels for bill processing have not yet been exhausted." The respondent has submitted documentation supporting that the fax number the requestor used to fax initial billing and the request for reconsideration was not the proper fax number. The respondent also included fax confirmation sheets showing the requestor has faxed bills that show same claimant to the correct fax number. Therefore, the disputed date of service has not been reviewed by the respondent; therefore, in accordance with 28 Texas Administrative Code §133.307(c)(2)(B) the requestor has not shown proof of request for reconsideration; therefore, the disputed date of service cannot be reviewed.
2. Review of the submitted documentation finds that reimbursement is not warranted.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $0.00

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services..

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 28, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.